Blood Donation Consent

PERSONAL INFORMATION

Full Name:

Gender:

Blood Unit No:

Telephone:

License No:

Mobile:

Birth Date:

E-mail:

Age:

Occupation:

Your Blood Group:

Have you donated previously?

When last ?

Did you have any discomfort during/after donation ?

Do you feel well today ?

Did you sleep well last night ?

Have you any reason to believe that you may be infected : By Hepatitis, Malaria, HIV and/or venereal disease (virinjay) ?

In the last 6 months have you had any history of the following ?

- [ ] Unexpected Weight Loss
- [ ] Repeated Diarrhea
- [ ] Swollen Glands
- [ ] Continuous Low-Grade Fever

In the last six months have you had any ?

- [ ] Tattooing
- [ ] Ear piercing
- [ ] Dental extraction

Do you suffer from or have suffered from any of the following diseases ?

- [ ] Heart disease
- [ ] Cancer/Malignant Disease
- [ ] Diabetes
- [ ] Hepatitis B/C
- [ ] Sexually Transmitted Diseases
- [ ] Typhoid (last 1 year)
- [ ] Lung Disease
- [ ] Tuberculosis
- [ ] Allergic Disease
- [ ] Kidney Dis
- [ ] Epilepsy
- [ ] Abnormal Bleeding Tendency
- [ ] Jaundice (last 1 year)
- [ ] Malaria (6 months)
- [ ] Fainting Spells

Are you taking or have you taken any of these in the past 72 hours?

- [ ] Antibiotics
- [ ] Steroids
- [ ] Aspirin
- [ ] Vaccinations
- [ ] Rabies Vaccine

Is there any history of surgery or blood transfusion in the past six months ?

- [ ] Yes
- [ ] No

For woman donors:

Are you pregnant ?

- ◯ Yes
- ◯ No

Have you had an abortion in the last three months ?

- ◯ Yes
- ◯ No

Do you have a child less than one year old ?

- ◯ Yes
- ◯ No

Would you like to be informed about any abnormal test result at the address furnished by you ?

◯ Yes ◯ No

Have you read and understood all the information presented and answered all the questions truthfully? As any incorrect statement or concealment may affect your health or may harm the recipient ?

◯ Yes ◯ No

General Physician Examination:

Weight:

Pulse:

Temperature:

Parental Consent:

By signing below, I authorize my child to donate blood. Further, unless indicated by checking the box below, I authorize my child to do so utilizing apheresis technology as described on the reverse of this sheet.

Parent/Guardian Name:

Parent/Guardian Signature:

Parent/Guardian Number:

I have understand that Blood donation is a totally voluntary act and no inducement or remuneration has been offered. Donation of Blood/components is a medical procedure and that by donating voluntarily. I accept the risks associated with this procedure. My blood will be tested for Hepatitis B/C, Malaria parasite, HIV/AIDS and venereal diseases in addition to any other screening tests required to ensure blood safety. I prohibit any information provided by me or about my donation to be disclosed to any individual or government agency without any prior permission.

Signature

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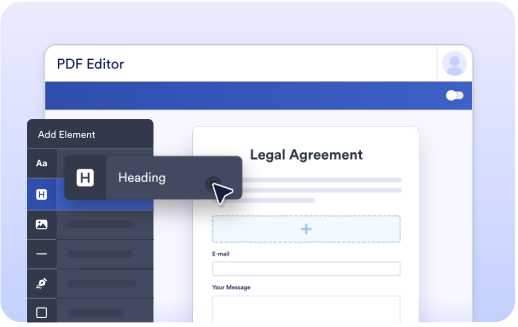

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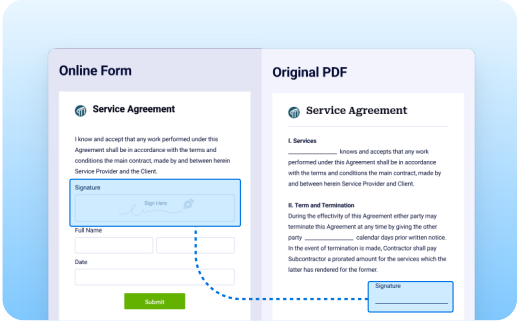

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